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SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1942

No. 291

FLORENCE H. McSWEENEY, INDIVIDUALLY AND AS ADMINISTRATRIX OF THE ESTATE OF EUGENE B. McSWEENEY, DECEASED,

Petitioner,

vs.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA,

Respondent.

PETITION FOR WRIT OF CERTIORARI AND SUPPORTING BRIEF.

DOUGLAS McKAY,
Columbia, S. C.,
GEORGE WARREN,
Hampton, S. C.,
THOS. M. BOULWARE,
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SUPREME COURT OF THE UNITED STATES

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No. 291

FLORENCE H. McSWEENEY, INDIVIDUALLY AND AS ADMINISTRATRIX OF THE ESTATE OF EUGENE B. McSWEENEY, DECEASED,

Petitioner,

vs.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA,

Respondent.

PETITION FOR WRIT OF CERTIORARI.

To the Honorable the Chief Justice and Associate Justices of the Supreme Court of the United States:

Your Petitioner, Florence H. McSweeney, respectfully represents that she is aggrieved by the final judgment and decision of the United States Circuit Court of Appeals for the Fourth Circuit, in the suit in equity, entitled No. 4910, Florence H. McSweeney, individually and as administratrix of the estate of Eugene B. McSweeney, appellant, *versus* The Prudential Insurance Company of America, respondent, decided June 4, 1942, and by reason thereof your petitioner prays for the allowance of a writ of certiorari

to be directed to the United States Circuit Court of Appeals for the Fourth Circuit, in order that the said judgment and decision may be reviewed by your Honorable Court.

I.

Summary Statement of Matter Involved.

This is a suit in equity, commenced in the District Court of the United States for the Eastern District of South Carolina, by respondent, The Prudential Insurance Company of America, against Eugene B. McSweeney, now deceased, and petitioner, Florence H. McSweeney, in which Respondent seeks to have rescinded and cancelled a life insurance policy in the sum of five thousand dollars issued by it on the life of the said Eugene B. McSweeney, with the said Florence H. McSweeney named as beneficiary. Before trial the insured died and, by consent, the beneficiary filed a supplemental answer, as beneficiary and as administratrix of said estate, alleging the insured's death and setting up a cross action for the recovery of the amount of the policy.

The Bill of Complaint contains the usual allegations of an action for recision and cancellation, and the basis upon which the relief is sought as upheld by the Master, is the charge that the insured in his application for the policy had fraudulently made certain material misrepresentations which entitled the insurance company to cancellation, to-wit: in answering question 7-A as to albumin, blood or sugar in urine and abnormal high blood pressure; 9-A as to being attended by a physician during the past three years, giving dates, complaints, doctors' names and addresses; and 10-B as to completeness of answers to questions 6, 7, 8 and 10-A.

The issues of law and fact were referred to a special master, Hon. E. W. Mullins of the Columbia, S. C., bar,

to hear the evidence and make and report his findings of fact and conclusions of law, who reported as a conclusion of fact, pertinent here:

> "5. I conclude that the evidence is insufficient to show that the insured at the time of making the representations in question had a conscious design or intent to defraud the insurance company."

and as a pertinent conclusion of law, that:

> "3. Representations of material facts within the insured's personal knowledge such as those here involved, relied upon by the insurance company, and which were untrue and known by the insured to be untrue when made, invalidate the policy even in the absence of proof of a conscious design or intent on the part of the insured to defraud the insurance company."

The discussion of the Master on which the foregoing findings are primarily based is given in footnote.[1]

By a formal order, the Judge Designate in the District Court, the Honorable A. W. Barksdale of Lynchburg, Vir-

[1] "As I have already stated, the evidence in this case falls far short of convincing me that the insured had an actual conscious intent to defraud the insurance company. On the question of intent it is impossible to say what was in Mr. McSweeney's mind when he stated that he had not consulted a physician other than Dr. Boyd, or had never had high blood pressure. Bearing in mind the evidence of the good character of the insured, which, under the South Carolina decisions, is an element to be considered, and the further fact that the insured, when he answered the questions, may have honestly thought that he had recovered from the conditions about which he had been previously advised by Dr. Levy, it is not unreasonable to assume that he had no conscious design or intent to defraud the insurance company. If, under the law of South Carolina, it is necessary for complainant to establish an actual design or scheme to defraud then the relief by way of cancellation should be denied. The question is not free from doubt and in fact has given me a great deal of concern by reason of certain general statements in some of the South Carolina decisions, to which I will later refer. Nevertheless I have reached the conclusion that under the law of South Carolina material representations, such as those here involved, relied on by the insurance company, which were untrue when made, invalidate the policy even in the absence of proof of a conscious scheme or design on the part of the insured to defraud the insurance company."

ginia, approved the master's findings of fact and conclusions of law, and adopted the same as those of the District Court. Upon appeal by Petitioner, McSweeney, to the Circuit Court of Appeals for the Fourth Circuit, that court, for the reasons stated in its opinion, entered June 4, affirmed the Decree appealed from. By order of July 2, 1942, mandate was stayed for thirty days, and by order of July 30 for twenty days. The reasons given in said opinion, briefly stated, in accordance with our understanding thereof, are that conscious *intent* on the part of insured *to deceive* need not have existed, that the requisite intent to deceive may be inferred from insured's signature to the application containing the untrue answers, and that the Circuit Court of Appeals has "full power" to review the findings of fact the pertinent portions of the decision being as quoted in footnote.[2]

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[2] "We think it clear that fraud of the sort required to avoid the policy is shown to exist where there is a false representation as to a material matter, which is false to the knowledge of the applicant at the time it is made and which is made for the purpose of being acted on by the company. Where these facts appear, *it is idle to inquire further whether there was an intent to defraud; for the intent to defraud in such case is the intent to obtain the policy by the false representations. Any question as to whether the insured may honestly have thought that he had recovered from the serious ailment from which he knew that he had suffered and for which he had consulted a physician is beside the point.*"

"While the cases relied on are authority for the position that a fraudulent intent in addition to the false representations there shown is necessary to establish fraud, *they are not authority for the position that fraudulent intent is not to be inferred from the making of the false representations* which are false within the knowledge of the person making them and are material and made to be acted on; and they do not militate against the holding of the Johnson case to the effect that fraudulent intent must be inferred from such representations when no other conclusion can reasonably be drawn from them. In the second place, the case was one heard in equity and not at law; and this court has *full power* to review the findings of fact. We entertain no doubt upon the evidence appearing in the record that the making of the false answers in the application as to matters inquired about, which were false to the knowledge of the applicant when making them, established fraud vitiating the policy *within the holding of the Johnson case.*

II.

Basis of Jurisdiction of Supreme Court.

Jurisdiction rests upon section 240-a of the Judicial Code, as amended by the Act of Congress of February 13, 1925, 43 Stats. 936, conferring jurisdiction to review any judgment of the Circuit Court of Appeals; and section 5-b of Rule 38 of the Supreme Court; together with diversity of citizenship and the jurisdictional amount.

III.

Questions Presented.

1. Is the decision herein in conflict with the law of South Carolina, as expounded by its highest court, in a number of cases, that in actions of this character the insurer must prove as a matter of fact, by clear and convincing *evidence, in addition to the mere signing of the application* containing the false answers, *that the insured had an actual or conscious intent or design to deceive and defraud the insurance company* in making the answers complained of.

2. Is the decision herein in conflict with the decisions of other Circuit Courts of Appeal as to the measure of proof required to make such a concurrent finding of fact "clearly erroneous" within the meaning of Rule 52-a of the Rules of Civil Procedure, if this Court should construe the decision herein (contrary to our construction thereof) as reversing the concurrent finding of fact by the Master and District Judge, based on inferences from oral testimony in conflict with deductions from other evidence, that the insured herein had no conscious intent to deceive and

defraud the insurance company, some of such decisions rendered in 1942 being cited in footnote.[3]

IV.

Reasons Relied Upon for Allowance of the Writ.

1. That the Circuit Court of Appeals has decided herein an important question of South Carolina law in a way probably in conflict with applicable decisions of the Supreme Court of South Carolina and this decision will control the many suits involving this question that may be brought in or removed to the Federal Courts in South Carolina in future years. It is a matter of public knowledge that many of the South Carolina policies are issued by insurance companies incorporated under the laws of other States and that many suits based on such policies, involving more than $3,000.00 and arising within the contestable period, are either commenced in the Federal Courts of South Carolina by such foreign insurance companies or removed to the Federal Courts when commenced in the State Courts by the insured. The court records will show that there are relatively a large number of these cases, and petitioner respectfully submits that this decision will bring about the very situation supposedly remedied by this Honorable Court in *Erie R. R.* v. *Tompkins,* 304 U. S. 64, and as to which this Court said, in *Fidelity Union Trust Co.* v. *Field,* 311 U. S. 169, 85 L. Ed 109: "The question has practical aspects of great importance in the proper administration of justice in the Federal Courts."

2. Petitioner further respectfully submits that, for the benefit of both the Bench and the Bar, the confusion ap-

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[3] 9th Cir. (1942) *Smith* v. *Royal Ins. Co.,* 125 F. 2nd 222; 3rd Cir. (1942) *Floridin Co.* v. *Clay,* 125 F. 2nd 669; 5th Cir. (1942) *Texas Agri. Assn.* v. *Hidalgo,* 125 F. 2nd 829; 8th Cir. (1942) *Adair* v. *Reorganization Inv. Co.,* 125 F. 2nd 901; 1st Cir. (1942) *U. S.* v. *State St. Trust Co.,* 124 F. 2nd 948.

parent in the application of Rule of Civil Procedure No. 52(a) by the several Circuit Courts should be cleared up by a definite construction and application of that rule by this Honorable Court.

Respectfully submitted,

FLORENCE H. McSWEENEY,
Petitioner.

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Hampton, S. C.;
THOS. M. BOULWARE,
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SUPPORTING BRIEF.

I.

Index to brief is included in Index to Petition, *supra.*

II.

The Opinion of the Court of Appeals.

This opinion was filed June 4, 1942, but is not yet reported.

III.

Grounds on Which Supreme Court Jurisdiction Is Invoked.

This application for writ of certiorari is made upon authority of section 240-a of the Judicial Code, as amended by the Act of Congress of February 13, 1925, 43 Stats. 936 and section 5-b of Rule 38 of this Court; and upon the grounds:

(1) That the said Circuit Court of Appeals has decided, herein, an important question of local law in a way probably in conflict with applicable local decisions; and

(2) Certiorari should be granted to fix the measure of proof required to justify the Circuit Court of Appeals in reversing a concurrent finding of fact, based on inferences from oral testimony in conflict with deductions from other evidence, by a Master and District Court, if this Court should decide (contrary to our opinion), that the Circuit Court of Appeals for the Fourth Circuit has in fact reversed such concurrent finding herein.

The date of the Decree sought to be reviewed is June 4, 1942. The mandate was stayed by Order of July 2, 1942, for thirty days, and by Order of June 30 for twenty days.

IV.

Statement of Case.

This is an action for cancellation of an insurance policy for $5,000.00 on the life of Eugene B. McSweeney, with his wife, petitioner, as beneficiary, upon the ground that he was guilty of fraud in stating in the application that he had not had high blood pressure and that Dr. Boyd was the only physician who had treated him within the preceding three years, which statements were not true (R. 10 & 11). The insured having died before the trial, petitioner by supplemental answer set up a cross action for recovery of the amount of the policy. The Court ordered a Special Master to hear the evidence and make and report his findings of fact and law (R. 8). The Master found that the insured had no conscious design or intent to deceive or defraud in making the untrue answers (R. 14), but that, as a matter of law, under the South Carolina decisions, such intent or design was not necessary for cancellation (R. 14).

The District Judge Designate, Hon. A. W. Barksdale of Virginia, adopted the Master's findings of fact and law (R. 32), and the Circuit Court of Appeals affirmed the judgment (R. 45), upon the ground, as we understand the decision, that the South Carolina law, as expounded in *Johnson* v. *N. Y. Life Insurance Company*, and other cases, 165 S. C. 494, does not require the insurer in such cases to prove by *evidence in addition* to the mere signing of the application containing the untrue answers that the insured had a *conscious* intent or design to deceive or defraud the insurer (R. 42); and with that construction of the decisions of the South Carolina Supreme Court, in mind, the Court then held (R. 43):

> "In the second place, the case was one heard in equity and not at law; and this court has *full power* to re-

view the findings of fact. We entertain no doubt upon the evidence appearing in the record that the making of the false answers in the application as to matters inquired about, which were false to the knowledge of the applicant when making them, established fraud vitiating the policy *within the holding of the Johnson Case.*"

The policy in question also provided "* * * and all statements made by the insured in the absence of fraud shall be deemed representations and not warranties * * *." (R. 3).

V.

Specification of Assigned Errors.

1. The decision herein is in conflict with the law of South Carolina, as expounded by its highest court in many cases that in actions of this character the insurer must prove as a matter of fact, by clear and convincing *evidence, in addition to the mere signing of the application* containing the false answers, that the insured had an *actual or conscious intent or design to deceive and defraud* the insurance company in making the answers complained of.

2. The decision herein is in conflict with the decisions of other Circuit Courts of Appeals as to the measure of proof required to make such a concurrent finding of fact "clearly erroneous" within the meaning of Rule 52-a of the Rules of Civil Procedure, if this Court should construe the decision herein (contrary to our construction thereof) as reversing the concurrent finding of fact by the Master and District Judge, based on inference from oral testimony in conflict with deductions from other evidence, that the insured herein had no conscious intent to deceive and defraud the insurance company.

VI.

Specification No. 1.

Confidently we assert that the well settled law in South Carolina, as shown in the following cases, is that the insurer must:

(a) bear the burden of proving that there was *conscious* intent or design of the insured to deceive or defraud; and

(b) prove such conscious intent or design *by evidence in addition to* insured's signature to the application containing the untrue answers.

On this point the Master says:

> "As I have already stated, the evidence in this case falls far short of convincing me that the insured had an actual conscious intent to defraud the insurance company. On the question of intent it is impossible to say what was in Mr. McSweeney's mind when he stated that he had not consulted a physician other than Dr. Boyd, or had never had high blood pressure. Bearing in mind the evidence of the good character of the insured which, under the South Carolina decisions, is an element to be considered, *and the further fact that the insured, when he answered the questions, may have honestly thought that he had recovered from the condition about which he had been previously advised by Dr. Levy, it is not unreasonable to assume that he had no conscious design or intent to defraud the insurance company.* If, under the law of South Carolina, it is necessary for complainant to establish an actual design or scheme to defraud then the relief by way of cancellation should be denied. The question is not free from doubt and in fact has given me a great deal of concern by reason of certain general statements in some of the South Carolina decisions, to which I will later refer. Nevertheless I have reached the conclusion that under the law of South Carolina material representations, such as those here involved, relied on by the

> insurance company, which were untrue, and known by the insured to be untrue when made, invalidate the policy even in the absence of proof of a conscious scheme or design on the part of the insured to defraud the insurance company."

And the Circuit Court of Appeals says:

> "We do not find it necessary to explore that distinction. We think it clear that fraud of the sort required to avoid the policy is shown to exist where there is a false representation as to a material matter, which is false to the knowledge of the applicant at the time it is made and which is made for the purpose of being acted on by the company. Where these facts appear, it is idle to inquire further whether there was intent to defraud; for the intent to defraud in such case is the intent to obtain the policy by the false representations. Any question as to whether the insured may honestly have thought that he had recovered from the serious ailment from which he knew that he had suffered and for which he had consulted a physician is beside the point." (R. 42).

In the following South Carolina cases, this question arose in actions at law, and the purpose of the State Supreme Court was simply to establish and continue to apply the law of this state as to these two prerequisites to cancellation and avoidance of life insurance contracts for fraud.

Huestess v. *South Atlantic,* 88 S. C. 31. The answers as to diseases, injuries, treatments, and physicians, were false. Insured wrote his signature at the required places. The agent and also the examining physician were undoubtedly guilty of fraud. Whether or not insured was guilty of fraud was disputed, but the Circuit Judge held that he was, and granted a non-suit. What kind of fraud? The Supreme Court says:

> "Under these circumstances, the question whether the insured was guilty of CONSCIOUS fraud should have been submitted to the jury."

Next, *Wingo* v. *N. Y. Life,* 155 S. C. 206. The following excerpts sufficiently give the facts, and show that *"intent to deceive," "A wicked intent"* is necessary for cancellation, and that it must be proved by clear and convincing evidence:

> "But, assuming that question 9 reasonably suggested to the applicant his duty to answer if he had aforetime consulted a physician thereabout, and that the answer 'No' was a response to that question, yet such an answer is only fatal when it is prompted by the intent to deceive. That inquiry involves a secret operation of the mind, and the circumstances before recited do not leave the issue free from reasonable doubt.
>
> "In this connection the eighth exception is relevant. Nobody will deny that in a court of equity the rule prevails that fraud must be proved by clear and convincing testimony, and that because it involves the wicked intent."

Southeastern v. *Palmer,* 129 S. C. 432. While this decision appears to be based both upon the question of conscious fraud and upon the fact that there was evidence that the company did not rely upon the false answers, still, the Court follows, with approval, the *Huestess* case, saying:

> "As to whether there was fraud on the part of the applicant was a question for the jury. Conscious fraud could not be inferred from mere inaccurate answers, especially when the answers were written by the agent of the company, and the testimony shows a subsequent thorough investigation by the company of the applicant's physical condition, independent of the answers of the applicant.
>
> "His honor committed no error in submitting the case to the jury for their determination. Under the case

of Huestess *v.* South Atlantic Life Insurance Company, 88 S. C., 31, 70 S. W., 403, a case very similar to this, this Court says in the opinion:

"'There is no direct or positive testimony tending to show that the insured intended to practice a fraud upon the defendant other than the mere inference, arising from the signing of the application for insurance, containing the answers alleged to be false.'

"In that case this court held that under the circumstances the question whether the insured was guilty of conscious fraud should have been submitted to the jury."

In *Stewart* v. *Pioneer Pyramid Life*, 177 S. C. 132 (1935), the Court says:

"We may dispose of the second of these propositions in a few words. It was a question for the jury to say whether the insured *intentionally and for the purpose of committing a fraud* on the insurer, concealed material facts from the insurer. *This is the settled rule of this jurisdiction.*"

and again, quoting from the *Johnson* case:

"Where a statement of fact in an application is only a representation, *its mere falsity is not sufficient to avoid the policy,* its materiality and the good faith of the applicant in making it being important considerations. Under the issues made in the case at bar, it would be necessary for the defendant to show that the statements in the application relied on to defeat the policy were untrue, that their falsity was known to the applicant, that they were material to the risk and relief on by the insurer, *and that they were made with intent to deceive and defraud the company.*

Other South Carolina cases to the same effect are treated in footnote.[4]

[4] In *Rogers* v. *Atlantic Life,* 135 S. C. 89 (1926) the appeal was from refusal of the trial Judge to direct a verdict for insurer, one of the questions being "have you ever undergone any surgical operation" to which the answer was untrue. The Supreme Court says:

"The question as to whether James A. Rogers, in answering "no" to these questions, *intended to defraud and deceive the insurance company* was properly, under the testimony, submitted to the jury."

"In *Johnson* v. *New York Life,* 165 S. C. 494 (1932), the South Carolina Supreme Court directed that a verdict be entered for the insurer upon the ground that no reasonable inference could be drawn from the evidence other than that the insured *deliberately intended to deceive* the company and thereby procure the insurance. That intent was the only inference that could be drawn from the testimony, showing that insured was a confirmed drunkard, that during the five years preceding the application he had been treated by physicians, which he denied, for alcoholism on ten different occasions, on one of which he was confined to a hospital, that some of such periods of illness would last from one to four weeks. Insurer did not seek to cancel the policy on misrepresentations as to use of alcohol, but the testimony was considered for the purpose of showing the nature and extent of the ailment for which he was treated and his intent in answering untruly.

"The principles of law applied in the decision are that there must be intent to deceive, and that as to this, "the mere signing of the application containing the answers alleged to be false is not conclusive."

In *Suggs* v. *New York Life,* 174 S. C. 1 (1934), the Court quotes from the decision in *Johnson* v. *New York Life,* as follows:

"Finally, the intent with which representations or misstatements of facts are made is a thing that is locked up in the heart and consciousness of the applicant. It may be shown by his express words, or it may be deduced from his acts and the facts and circumstances surrounding the making of the misrepresentations, though on this question the mere signing of the application containing the answers alleged to be false is not conclusive. *Huestess* v. *Inc. Co.,* 88 S. C. 403." (Italics added by the Court.)

In the dissenting opinion, Mr. Justice Bonham quotes from the *Johnson* case, as to misrepresentations, that the insurer must show "that they were made with intent to deceive and defraud the insurance company" and says: "We will apply that yardstick to the present case."

Livingston v. *Union Central Life,* 120 S. C. 93. In his concurring opinion, the brilliant Mr. Associate Justice Maron says:

"In the light of the foregoing consideration, so pointedly recognized in the exercise of the legislative power of the state, I think there are salutary reasons, *grounded in sound public policy,* for not applying the rule that the erroneous or untrue but not fraudulent representation of a material fact by an applicant will avoid or forfeit a life insurance policy after a right of action has accrued thereon and the lips of one of the parties to the contract have been effectually sealed by death."

The case of *Murray* v. *Metropolitan,* 193 S. C. 368, relied upon by the Circuit Court of Appeals, involving *reinstatement* of a policy, is easily distinguished from cases involving misrepresentations in an application for the *issuance* of a policy. The contract between the parties is wholly different and the only things considered were the terms of the contract and the falsity of the answers. The court below has certainly misinterpreted the *Murray* case, wherein it is said:

> "The appellant complains that the lower Court erred in refusing its motion for the direction of a verdict upon the ground that the Court should have held that the only reasonable inference to be drawn from the evidence was that the answers to the question in the application were material and untrue, and therefore, *according to the specific agreement contained in the reinstatement application,* the defendant was under no liability for a period of two years, and was within its rights in declaring the policy null and void.
>
> "With the application for reinstatement in evidence, and with the undisputed testimony submitted by the defendant showing the falsity of the representations therein made, it conclusively appears that the motion for a directed verdict should have been granted unless there was also evidence of waiver to take the case to the jury."

Atlantic Life Insurance Co. v. *Hoeffer,* (4th Cir.) 66 F. (2d) 464. We merely call attention to the fact that this decision was rendered prior to *Erie R. R.* v. *Tompkins.*

VII.

Specification No. 2.

The decision herein is in conflict with the decisions of other Circuit Courts of Appeal as to the measure of proof required to make such a concurrent finding of fact "clearly

erroneous'' within the meaning of Rule 52-a of the Rules of Civil Procedure, should this Court construe the decision herein (contrary to our construction) as reversing the concurrent finding of fact. Some of these decisions are:

Third Circuit. *Floridin Co.* v. *Clay,* 125 F. (2d) 669 (in equity) holding:

> "This finding is supported by substantial evidence and is thus controlling here on appeal."

First Circuit. *U. S.* v. *State St. Trust Co.,* 124 F. (2d) 948 (action to recover income taxes) holding:

> "A finding cannot be set aside unless it is clearly erroneous, that is, against the clear weight of the evidence."

Eighth Circuit. *Adair* v. *Reorganization Inv. Co.,* 125 F. (2d) 901 (action to recover assessment or bank stock) holding:

> "* * * and its findings are presumptively correct, unless some obvious error of law has intervened or some serious mistake of fact has been made."

Fifth Circuit. *Texas Agri. Assn.* v. *Hidalgo,* 125 F. (2d) 829 (in equity) holding:

> "as this is a suit in equity, we are not bound by the conclusions of the District Court and may look to the entire record in deciding the case."

Ninth Circuit. *Smith* v. *Royal Ins. Co.,* 125 F. (2d) 222 (action on fire policy) holding:

> "The doubtful issue should have been resolved against the party upon whom rested the burden of proof."

In the decision herein, the court below merely states that it has *full power* to review the findings of fact. If it has, in fact, reversed this concurrent finding of fact, then

"full power" must mean the power to ignore the oral testimony, and is therefore not akin to "clearly erroneous."

Frankly, however, we do not think that the finding of fact has been reversed, because the Court says that the evidence establishes fraud vitiating the policy *within the holding of the Johnson case,* and we think the error really lies in its construction of the *Johnson case* and other South Carolina decisions.

Respectfully submitted,

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(1574)

BRIEF IN OPPOSITION TO PETITION
FOR WRIT OF CERTIORARI

Supreme Court of the United States

OCTOBER TERM, 1942

No. 291

FLORENCE H. McSWEENEY, INDIVIDUALLY AND AS ADMINISTRATRIX OF THE ESTATE OF EUGENE B. McSWEENEY, DECEASED, PETITIONER

versus

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA, RESPONDENT

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Supreme Court of the United States

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No. 291

FLORENCE H. McSWEENEY, INDIVIDUALLY AND AS ADMINISTRATRIX OF THE ESTATE OF EUGENE B. McSWEENEY, DECEASED, PETITIONER

versus

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA, RESPONDENT

STATEMENT

This is an action in equity in the District Court of the United States for the Eastern District of South Carolina by respondent, The Prudential Insurance Company of America, a corporation under the laws of the State of New Jersey, and a citizen and resident of that State, against Eugene B. McSweeney and Florence H. McSweeney, his wife, citizens and residents of the town of Allendale, South Carolina, in that District, to rescind a policy of life insurance in the amount of Five Thousand Dollars ($5,000.00) issued by respondent upon the life of McSweeney, in which his wife was named as beneficiary. McSweeney died during the pendency of the action, and an amended answer was filed by Mrs. McSweeney individually and as his administratrix, pursuant to a consent order, which answer contests respondent's right to have the policy rescinded, and contains a counterclaim for the face amount of the policy.

By a general order of reference the cause was referred to E. W. Mullins, Esquire, an attorney of the Columbia, South Carolina, bar, as Special Master, who took the testimony and filed his report, finding and recommending that "under the law of South Carolina the circumstances here proved entitle the insurer to have the policy rescinded." The cause was heard in the District Court by the Honorable A. D. Barksdale, United States District Judge for the Western District of Virginia, sitting by assignment in the Eastern District of Souh Carolina, on exceptions filed by both parties to the report. Judge Barksdale filed an order overruling all exceptions to the report, and granting the prayer of the bill of complaint.

It was alleged in the bill of complaint and proved by the evidence that:

The policy in question was issued upon a written application by McSweeney which included certain declarations made to Dr. F. H. Boyd, respondent's medical examiner, and signed by McSweeney. Certain questions were asked by the company and answered by McSweeney, including a question as to whether he had ever had "abnormal blood pressure," which question he answered in the negative. Another question was whether he had been attended by a physician during the past three years, calling for dates, doctors' names and addresses, which question he answered by stating that he had had malarial fever in 1932, from which he had completely recovered, and for which he had been treated by Dr. F. H. Boyd of Allendale, South Carolina. Another question was whether his answer to the preceding questions constituted a complete statement of all his illnesses, etc., which he answered in the affirmative.

The policy was duly issued, being dated February 14, 1935, and under date of March 19, 1936, a claim was made by McSweeney upon respondent for waiver of further premiums on the policy because of his total and permanent disability. The claim was supported by a certificate of Dr. Boyd, as attending physician, that McSweeney showed impairment of speech

and numbness, which he diagnosed as hemorrhage of the brain, rendering him totally disabled.

Upon receipt of this claim, respondent caused an investigation to be made, in the course of which it was discovered for the first time that on October 18, 1932, November 1, 1932, and December 26, 1932, McSweeney had consulted Dr. M. S. Levy, of Augusta, Georgia, complaining of numbness of the left side of his face, arm and leg on the left side, and thickness of the tongue; that Dr. Levy had examined him and found that he was suffering from abnormal blood pressure and that his arteries were sclerotic; that Dr. Levy had told McSweeney that he had abnormal blood pressure and should take care of himself, and prescribed certain treatment and a thyroid extract for his condition. Dr. Levy's testimony at the hearing before the special master showed that McSweeney was "pretty badly impaired" (p. 29); that the symptoms were suggestive of a small hemorrhage in the brain and a chance of area paralysis (p. 29); that neither then nor after that time was McSweeney an insurable risk, or eligible for insurance (pp. 31, 32); and that his ultimate disability was a normal sequence of the conditions and symptoms appearing at the time of his examination of McSweeney in 1932, and was actually what Dr. Levy would have anticipated from such examinations (pp. 31, 34).

Upon discovering these facts, respondent tendered back the five quarterly premiums which had been received by it on the policy, with interest thereon, and demanded the surrender of the policy for cancellation. Such tender and demand were refused by McSweeney, and this action was immediately instituted by respondent, and the premiums and interest paid into the registry of the court.

In addition to Dr. Levy's testimony at the reference before the special master, the policy, the application, including the declarations made to the medical examiner, the medical examiner's report, and the proofs of total and permanent disability were offered in evidence by the respondent.

On behalf of appellant, it was testified to by the widow of Dr. Boyd, who had examined McSweeney for the policy, that Dr. Boyd had been McSweeney's family physician for years (p. 38), that her husband conducted his insurance examinations in his office in their living room (p. 37), that he was usually a very busy man and would get the principal data for the blanks and would fill in parts of what he knew as well as the family record he knew himself (p. 38), but that she could not say what was done in this particular case and did not know (p. 39). Mrs. McSweeney testified that she had accompanied her husband to Dr. Levy's office in Augusta (p. 40), and in fact had persuaded him to go (p. 43), that she heard what Dr. Levy told her husband and that it alarmed her about her husband's condition (p. 45), although her husband was not easy to alarm and was not alarmed as much as she was (p. 45); that she had urged him to go to see Dr. Levy because he was complaining then of numbness of his side and on one visit of thickness of speech (p. 43); and that during the years 1933 and 1934, he apparently felt well and she did not hear him complain at all (p. 41). One P. J. Fulmer, an agent for the respondent, testified that he had solicited the insured for the policy of insurance and had had some delay in getting McSweeney to go to Dr. Boyd to be examined (pp. 45-47).

In the course of Dr. Levy's testimony he stated that Dr. Boyd had referred McSweeney to him, and that in 1932 he had written Dr. Boyd a letter about the findings, although he did not have a copy of the letter (pp. 34-35).

In addition to the evidence given by the witnesses, an agreed statement of facts was filed in the cause, in which it was conceded by petitioner that the proper officer of the respondent would, if present, testify to the fact that the company relied on the declarations of McSweeney in issuing the policy, and that the questions asked were most material to the risk proposed to be assumed by respondent, and to the truth of paragraphs 11 and 12 of the bill of complaint, alleging in substance that the facts as to McSweeney's former condition of health and his former consultations and treatment by physicians, and his former illnesses,

had been misrepresented, and that respondent did not receive the information which it was entitled to under the written agreements contained in the application and declarations to the medical examiner, and that respondent issued the policy without knowledge of the same and relied on the representations and answers in issuing the policy, and that the policy would not have been issued if it had known the truth, or if the answers had been true, as true answers would have disclosed McSweeney as an uninsurable risk which respondent could not and would not have assumed in the proper conduct of its business and under its rules and regulations.

In his report, the special master found as a fact that "the answers to three questions were untrue, to wit, that he had never had abnormal blood pressure, that he had consulted Dr. Boyd alone in the past three years, and that his answers constituted a complete statement of all his illnesses," and that they "were known by the insured to be untrue." He also found as a fact that "the facts with reference to the insured's consultations with Dr. Levy and his admitted condition of abnormal high blood pressure were material to the risk and relied on by the insurer" and that the insurer "had no knowledge of the falsity of the said representations and would not have issued the policy had they known the true facts about the insured's consultations with Dr. Levy and his physical condition as developed from the examinations made by Dr. Levy" and that respondent "took prompt action to cancel and rescined the policy" as soon as it learned of the facts. He further found that although "the evidence is insufficient to show that the insured at the time of making the representations in question had a conscious design or intent to defraud the insurance company," "the effect and result of his making an application containing material representations of facts known by him to be false by which he secured the policy of insurance consitutes a legal fraud entitling the said company to a rescission or cancellation of the policy" (pp. 56-57).

On the question whether respondent was charged with the knowledge acquired by Dr. Boyd in 1932 from Dr. Levy when he acted as respondent's medical examiner in 1935, the special

master found as a fact that "the evidence fails to convince me that Dr. Boyd had in mind any information furnished him by Dr. Levy at the time he took insured's application for the policy in question, and cannot be presumed to have communicated it to the company" and "that the insurance company is not chargeable with such previously acquired knowledge of Dr. Boyd" (p. 57).

As a conclusion of law, the special master found that under the law of South Carolina "representations of material facts within the insured's personal knowledge such as those here involved, relied upon by the insurance company, and which were untrue and known by the insured to be untrue when made, invalidate the policy even in the absence of proof of a conscious design or intent on the part of the insured to defraud the insurance company;" and that "under the facts of this case the complainant insurance company is not chargeable with such knowledge as Dr. Boyd acquired from Dr. Levy with respect to the insured's consultations with Dr. Levy and insured's condition of high blood pressure" (p. 58).

The District Court approved and adopted the findings of fact and conclusions of law in the report of the special master, and judgment was entered thereon denying recovery on the policy and ordering its cancellation upon the return of the premiums paid, and from this judgment an appeal was taken to the United States Circuit Court of Appeals for the Fourth Circuit.

The Circuit Court of Appeals affirmed the judgment of the District Court, holding:

> "On these facts we think that the lower court correctly held that the policy was avoided as a result of the false representations contained in the application. Whether termed constructive fraud or not, there can be no question but that, under the law of South Carolina, such false representations, knowingly made by an applicant for insurance with respect to material facts necessarily within his knowledge, as distinguished from matters of opinion or matters

as to which there is possibility of mistake, constitute fraud as matter of law for which the policy may be cancelled. *Johnson v. N. Y. Life Ins. Co.* 165 S. C. 494, 164 S. E. 175."

In reference to the contention that the South Carolina decisions require proof that the insured had an actual or conscious intent or design to deceive and defraud the insurance company in making the answers complained of, and that the master's fifth conclusion of fact "that the evidence is insufficient to show that the insured at the time of making the representations in question had a conscious design or intent to defraud the insurance company" precluded the cancellation of the policy, the Circuit Court of Appeals referred to the fact that this finding of the special master grew out of the distinction drawn by him between moral fraud and constructive fraud, which distinction the court did not deem it necessary to explore, saying:

"We do not find it necessary to explore that distinction. We think it clear that fraud of the sort required to avoid the policy is shown to exist where there is a false representation as to a material matter, which is false to the knowledge of the applicant at the time it is made and which is made for the purpose of being acted on by the company. Where these facts appear, it is idle to inquire further whether there was intent to defraud; for the intent to defraud in such case is the intent to obtain the policy by the false representations. Any question as to whether the insured may honestly have thought that he had recovered from the serious ailment from which he knew that he had suffered and for which he had consulted a physician is beside the point. Inquiries were addressed to him with regard thereto as a basis for determining whether the policy should be issued; he knew that his answers would be taken into consideration and acted on by the company; and, when he made false answers which he knew to be false as a basis for such action, fraudulent intent in making them may reasonably be inferred. *Smith v. Vandiver* 149 S. C. 540, 147 S. E. 645. His good faith, under such circum-

stances, is not a matter for speculation, but must be determined from a consideration of what he has deliberately done. *Nettles v. Sottile* 184 S. C. 1, 191 S. E. 796, 805."

And further:

"While the cases relied on are authority for the position that a fraudulent intent in addition to the false representations there shown in necessary to establish fraud, they are not authority for the position that fraudulent intent is not to be inferred from the making of false representations which are false within the knowledge of the person making them and are material and made to be acted on; and they do not militate against the holding of the Johnson case to the effect that fraudulent intent must be inferred from such representations when no other conclusion can reasonably be drawn from them. In the second place, the case was one heard in equity and not at law; and this court has full power to review the findings of fact. We entertain no doubt upon the evidence appearing in the record that the making of the false answers in the application as to matters inquired about, which were false to the knowledge of the applicant when making them, established fraud vitiating the policy within the holding of the Johnson case."

The court then discussed the evidence and concluded that the undisputed facts can reasonably give rise to only one inference, namely, that the policy was procured by fraud.

The instant action was brought under the authorization of Section 7987 of the Code of Laws of South Carolina, 1932, which provided:

"Life insurance companies are hereby authorized to institute proceedings to vacate policies on the ground of the falsity of the representations contained in the application for said policy; *Provided,* That same be commenced within two years from the date of said policy."

The action was instituted within the period of contestability provided in that section, and in the policy itself, and in Section 7986 of the South Carolina Code, which reads:

> "All life insurance companies * * * that shall receive the premium on any policy for the space of two years shall be deemed and taken to have waived any right they may have had to dispute the truth of the application for insurance, or that the assured person had made false representations shall be deemed and taken to be true."

Because of these statutes and of the incontestable clause in the policy, there is jurisdiction in equity to entertain the action.

Jeffers v. New York Life Ins. Co., 34 F. (2d) 874.
Brown v. Pacific Mutual Life Ins. Co., 63 F. (2d) 711.

ARGUMENT

I.

The first question presented by the petition in the instant proceeding is whether the Circuit Court of Appeals misconstrued the law of South Carolina relating to the showing required in order to authorize rescission of life insurance policies for fraud in their procurement.

The Special Master found as a conclusion of fact that the policy in question was obtained by means of false representations, knowingly made by the insured, with respect to material facts necessarily within his knowledge, and that thereby the insured obtained the policy when he was admittedly an uninsurable risk, and when admittedly he would not have obtained it if the answers in response to which the false representations were made had been true. His finding was concurred in by the District Court and affirmed by the Circuit Court of Appeals.

It was held by the Special Master as a conclusion of law that the facts so proved warranted rescission of the policy under the South Carolina law, and the District Court approved this conclusion. The Circuit Court of Appeals affirmed this holding, and went further and held that, since the case was in equity, it could review the facts, and upon a review of the facts that Court held that the facts proved made out a case for rescission under the South Carolina decisions, even if not sufficient as a matter of law.

The Circuit Court of Appeals based its holding principally on the case of *Johnson v. New York Life Ins. Co.*, 165 S. C. 494, 164 S. E. 175, which was conceded by both sides in the Circuit Court of Appeals to be the leading case in South Carolina on the question. A consideration of that case will show that the decision assailed in the instant proceeding is clearly correct, and should not be disturbed.

In the *Johnson* case, the action was one at law brought to

recover on the policy of life insurance. The trial court left the issue of fraud in the procurement of the policy to the jury. On appeal, the Supreme Court of South Carolina reversed this ruling of the trial court, and held that a verdict in favor of the insurance company should have been directed.

Before entering upon a discussion of the evidence, the Supreme Court referred to the fact that the statements relied on by the company were representations and not warranties, and "that in order to avoid the policy, it must be shown that they were fraudulent." The court said:

> "Where a statement of fact in an application is only a representation, its mere falsity is not sufficient to avoid the policy, its materiality and the good faith of the applicant in making it being important considerations."

The court stated the issues on appeal as follows:

> "Under the issues made in the case at bar, it would be necessary for the defendant to show that the statements in the application relied on to defeat the policy were untrue, that their falsity was known to the applicant, that they were material to the risk and relied on by the insurer, and that they were made with intent to deceive and defraud the company."

The application in that case, written in the handwriting of the medical examiner of the company in accordance with information given by the applicant, (which was the case here) contained questions in reference to the applicant's use of intoxicants, which he answered in the negative, and also questions as to consultations with physicians within the preceding five years, which applicant answered by referring to an attack of influenza, and also to treatments with cold vaccine by a Dr. Ritter, and he then stated that he had been treated by no other physicians within the preceding five years.

The court summarized the testimony as follows:

> "The undisputed testimony shows that, during the five years immediately preceding the signing of the application, the insured had been treated by physicians for alcoholism on ten different occasions, on one of which he was confined to a hospital; that some of such periods of illness would last from one to four weeks; and that he was advised by one of the attending physicians to discontinue the use of alcohol as the physician thought it would ruin his health."

Pointing out that the decision of the case rested "solely upon the representations in the application as to the applicant's consultation with and treatment by physicians, and not at all upon the representations as to his drinking intoxicants," because the company's answer did not rely upon the latter representations, the court held:

> "It is inconceivable that, under the circumstances, the insured did not know that his answer to the question as to whether he had consulted a physician, etc., was untrue. The case is different in this respect from Rogers v. Insurance Co., 135 S. C. 89, 133 S. E. 215, 45 A. L. R. 1172, in which the question was whether the insured knew that he had suffered from cancer. One may well suffer from cancer without knowing it, and the evidence in that case was clearly susceptible of the inference that the insured did not know that he had that dread disease. In the case at bar the insured was treated on ten different occasions by physicians for alcoholism, which is a diseased condition of the system resulting from excessive drinking of alcoholic liquor. The facts clearly were of such nature that Johnson could not fail to know them when answering the questions in the application as to his consultation of physicians—certainly *they were of such nature that he would be conclusively presumed to know them.* See Gambrill v. Insurance Co., supra." (83 S. C. 236, 65 S. E. 231.) (Emphasis added)

After discussing the question of materiality, the court then considered the question of intent, as follows:

"Finally, the intent with which representations or misstatements of facts are made is a thing that is locked up in the heart and consciousness of the applicant. It may be shown by his express words, or it may be deduced from his acts and the facts and circumstances surrounding the making of the misrepresentations, though on this question the mere signing of the application containing the answers alleged to be false is not conclusive. Huestess v. Insurance Co., 88 S. C 31, 70 S. E. 403. Under the circumstances of this case, we do not see how any reasonable inference as to the applicant's intent in making his answer to the questions under consideration can be drawn from the undisputed facts other than that he deliberately intended to deceive the company and thereby procure the insurance."

In the *Johnson* case, the evidence disclosed ten occasions on which the applicant had consulted physicians within the preceding five years; in the instant case, there were three undisclosed occasions in the period from October 18, 1932, to February 14, 1935, a period of little more than two years. In the *Johnson* case, the evidence did not disclose an actual connection between the insured's condition and his death; in the instant case, the total disability of the insured, which occurred within a few months of the issuance of the policy, and his subsequent death, were directly connected with the condition which was concealed from the company by the failure to answer its specific questions truthfully. In the instant case, as in the *Johnson* case, the facts concealed were of such a nature that the applicant "would be conclusively presumed to know them." In the instant case, as in the *Johnson* case, no reasonable inference as to the applicant's intent in making his answer to the questions under consideration can be drawn from the undisputed testimony "other than that he deliberately intended to deceive the company and thereby procure the insurance."

If the instant case had been an action at law in the South Carolina courts, the trial judge, under the binding authority of the *Johnson* case, would have had to direct a verdict in favor

of the insurance company, as the Supreme Court held should have been done by the trial judge there.

In following and applying the *Johnson* case in the instant case, the Circuit Court of Appeals properly interpreted and gave effect to the law of South Carolina, and did not misconstrue that law. Had the Circuit Court of Appeals done otherwise, it would have made the same mistake that the Supreme Court of South Carolina held that the trial judge had made in not directing a verdict in favor of the insurance company in the trial court in the *Johnson* case. Under the facts here proved, the *Johnson* case was controlling, and should have been, and was, followed.

That the Circuit Court of Appeals properly interpreted the *Johnson* case is shown by the discussion of that case by the Supreme Court of South Carolina in *Parker v. Pacific Mutual Life Ins. Co.*, 179 S. C. 117, 183 S. E. 697, where the court said:

> "We think this case comes strictly within the rule and principle laid down in the case of *Johnson v. New York Life Insurance Co.*, 165 S. C. 494, 164 S. E. 175. In the *Johnson* case the insured stated that he had not been treated by, or had consultations with, physicians during the 5-year period prior to his application for insurance, whereas the evidence showed that he had on ten different occasions been treated for alcoholism. The Court said: 'The facts clearly were of such nature that Johnson could not fail to know them when answering the questions in the application as to his consultation of physicians—certainly they were of such nature that he would be conclusively presumed to know them.' *On the strength of this conclusion,* the court decided in the *Johnson* case that the facts could reasonably give rise to only one inference; namely, that the policy was procured in fraud." (Emphasis added.)

It is urged by petitioners that the South Carolina law requires proof of what is termed "an actual or conscious intent or design to deceive or defraud" the insurance company in order to authorize rescission of a policy of life insurance for fraud in its

procurement. The contention is, that since the Special Master, in his 5th conclusion of fact, found "that the evidence is insufficient to show that the insured at the time of making the representations in question had a conscious design or intent to defraud the insurance company," which conclusion was concurred in by the District Court, the evidence failed to make out a case for rescission despite the remaining findings and conclusions of the Special Master and District Judge.

The respondent duly excepted of the Special Master's 5th finding of fact, but its exception was overruled by the District Judge along with petitioner's exceptions to the Special Master's report.

It has already been pointed out, however, that the Circuit Court of Appeals reviewed the facts, as it had the power to do in an equity case, and held that the facts proved and the showing made are sufficient under the South Carolina decisions to establish the company's right to rescind the policy, discussing the question of intent at length, and holding that

> "Inquiries were addressed to him with regard thereto as a basis for determining whether the policy should be issued; he knew that his answers would be taken into consideration and acted on by the company; and, when he made the false answers which he knew to be false as a basis for such action, fraudulent intent in making them may reasonable be inferred. *Smith v. Vandiver,* 149 S. C. 540, 147 S. E. 645. His good faith, under such circumstances, is not a matter for speculation, but must be determined from a consideration of what he has deliberately done. *Nettles v. Sottile,* 184 S. C. 1, 191 S. E. 796, 805."

And further:

> "We entertain no doubt upon the evidence appearing in the record that the making of the false answers in the application as to matters inquired about, which were false to the knowledge of the applicant when making them, estab-

> lished fraud vitiating the policy within the holding of the *Johnson* case."

Petitioner's contention that an actual or conscious design or intent to deceive and defraud the insurance company must be proved as an absolute condition precedent to rescission is based upon selected phases taken from several decisions of the South Carolina Supreme Court, which appear to be *dicta* or surplusage when the facts of the cases are considered. Her contention ignores the principle, adverted to by the Special Master, and stated and recognized by this court in *Cohens v. Virginia*, 6 Wheat. 264, 399, 5 L. Ed. 257, 290, that

> "It is a rule of universal application that general expressions used in a Court opinion are to be taken in connection with the case under consideration."

One case relied on by petitioner is *Huestess v. South Atlantic Life Ins. Co.*, 88 S. C. 31, 70 S. E. 403, which appears to have been the first case applying the "good faith" rule in South Carolina. In that case, the evidence showed that the applicant informed the agent of the company that he had a serious ailment, and had been declined for life insurance, but the agent undertook to get him accepted by the company and passed by its medical examiner, stating to the applicant that he had just gotten a policy issued in a similar case. There was a question whether the answers in the application had been filled in before or after the insured signed it, and under all of the circumstances the court held that the issue of fraud was one for the jury, and that *the issue made by the pleadings* was "conscious" fraud, which the company had the burden of *proving as alleged*. The Court did not pass upon the character or kind of fraud required for rescission, merely accepting the issue as made by the pleadings.

In *Wingo v. New York Life Ins. Co.*, 155 S. C. 206, 101 S. E. 653, the Court merely held that the issue of fraud was not free from reasonable doubt, and was for the jury.

In *Southeastern Life Ins. Co. v. Palmer*, 129 S. C. 432, 124 S. E. 577, the Court emphasized strongly that the insurer did not rely on the application in issuing the policy there in question, but had had the insured further examined and had conducted extensive investigations before assuming the risk. Holding that the mere signing of the application did not conclude the question of fraud, the issue was held to be for the jury. It is of interest to note that Circuit Judge Parker, who wrote the opinion of the Circuit Court of Appeals in the instant case, was of counsel in the *Palmer* case.

In *Stewart v. Pioneer Pyramid Life Ins. Co.*, 177 S. C. 132, 180 S. E. 889, the Court recognized the fact that *Johnson v. New York Life Ins. Co., supra,* is the leading case in South Carolina, but held that under the facts in that case the issue was one for the jury.

Rogers v. Atlantic Life Ins. Co., 135 S. C. 89, 133 S. E. 215, 45 A. L. R. 1172, cited by petitioner, has been explained by the South Carolina Supreme Court in several cases. In *Parker v. Pacific Mutual Life Ins. Co., supra,* the court said:

> "The case at bar is easily distinguished from the case of Rogers v. Insurance Co., ... in which the question was whether the insured knew that he had suffered from cancer. Rogers was a layman, and as was said in the *Johnson* case, *supra,* 'one may well suffer from cancer without knowing it'; and it may be added that Rogers had never had a definite diagnosis of his condition made as cancer."

In the same opinion, the court discussed *Suggs v. New York Life Ins. Co.*, 174 S. C. 1, 176 S. E. 457, also cited by petitioner, saying:

> "This case is also clearly distinguishable from the later case of *Suggs v. New York Life Ins. Co.*, ... In the *Suggs* case the evidence showed that the insured, a man of good character, might not have known the real condition of his health at the time he applied for the insurance."

It is interesting to note that in the *Suggs* case, which, like the instant case, involved high blood pressure, there were two opinions, one which became the leading opinion and which was signed by two Justices, and another opinion which became the dissenting opinion, which was also signed by two Justices. The fifth Justice concurred in the result of the leading opinion.

In the dissenting opinion, it was said that

> "The case of *Atlantic Life Insurance Co. v. Hoefer*, ... 66 F. (2d) 464, 465, is in such exact analogy with our case, and so aptly discusses and decides the very questions we are interested in, that we quote from it copiously."

The leading opinion distinguished the *Suggs* case from the *Johnson* case by saying:

> "The evidence does not show that the applicant knew or believed that he was seriously ill, and his reputation for honesty and fair dealing, if the witnesses were to be believed, was never questioned. Undoubtedly, in the light of these facts and circumstances, it was for the jury and not for the court to determine the issue made."

In *Livingston v. Union Central Life Ins. Co.*, 120 S. C. 93, 112 S. E. 547, it appears that counsel for the insurance company stipulated on the record during the trial that he did not allege or charge fraud on the part of the insured, and the court held that this was an admission that the insured did not know that his answers in the application were false in fact. Fraud being essential to rescission, it was held that the case was not made out. Compare *Livingston v. Union Central Life Ins. Co.*, 115 S. C. 128, 104 S. E. 538.

From these, and several other South Carolina cases not cited by petitioner, it will be seen that the expressions relied on by petitioner in each case, when referred to the facts of the particular case, mean nothing more nor less than that proof of fraud is essential to the rescission of a life insurance policy, and that

good faith on the part of the applicant inconsistent with the existence of fraud in a particular case defeats an action for rescission, despite the making of answers actually untrue in fact in an application for a policy.

None of the decisions cited, however, uphold petitioner's contention that, in spite of a showing that false answers were made, which the applicant knew to be false when he made them, and which were material and relied on by the company, and which were intended to, and were successful in, obtaining the issuance of a policy which the applicant was in fact not entitled to, and which would not have been issued except for the knowingly false answers, is not sufficient without further proof of an actual or conscious design or intent to defraud the company. Good faith, when proved, may defeat an allegation of fraud; but this is as far as good faith in such cases goes, in South Carolina or elsewhere. Where, as here, good faith is not shown, but on the contrary the proof establishes bad faith, the making of false answers knowing them to be false when made, the fraud necessary to rescind the policy has been established under the South Carolina law, as was held in *Johnson v. New York Life Ins. Co., supra,* and the Circuit Court of Appeals properly followed and applied that case in the instant case.

The *Johnson* case was decided subsequent to any of the cases cited by petitioner, except the *Stewart* case, which recognized it as the leading case, and the *Johnson* case has been referred to as the leading case in the State and followed in practically every case decided later.

Petitioner's contention would seem to suggest that there is something peculiar in the South Carolina doctrine of fraud, but that is not the case. The elements of actionable fraud in South Carolina have been defind by the Supreme Court of that State as recently as March 23, 1942, in the case of *McKay v. Anheuser-Busch, Incorporated,* (S. C.) 19 S. E. (2d) 457, as follows:

> "To constitute actionable fraud there must appear (1) a representation; (2) its falsity; (3) its materiality; (4) the author's knowledge of its falsity or ignorance of its truth; (5) his intention that it should be acted upon by the person and in the manner reasonably contemplated; (6) the other party's ignorance of its falsity; (7) his reliance on its truth; (8) his right to rely thereon; and (9) his consequent and proximate injury thereby."

See also *Flowers v. Price*, 190 S. C. 392, 3 S. E. (2d) 38, and *Halsey v. Minnesota-South Carolina Land & Timber Co.*, 174 S. C. 97, 177 S. E. 29, 100 A. L. R. 1.

In South Carolina, actionable fraud may be established without proof of "actual, moral fraud." In *Lagrone v. Timmerman*, 46 S. C. 372, 24 S. E. 290, the court held:

> "That (the) question is whether the defendants can be held liable without proof of actual, moral fraud on their part. The point is so conclusively determined by the authorities in this state, adversely to the view contended for by appellants, that we need not go elsewhere for authority."

In *State v. Strong*, 185 S. C. 27, 192 S. E. 671, the court said:

> "Just as nature abhors a vacuum, so equity abhors a wrong without a remedy. Constructive fraud has the same legal effect as actual fraud."

In *Smith v. Vandiver*, 149 S. C. 540, 147 S. E. 645, the court held that the complaint stated a cause of action in fraud, saying:

> "It is sufficiently alleged that the statements made by the defendant which induced the plaintiff to leave her deposit in the bank were untrue when made, and that the defendant then knew them to be untrue, or in his position, as the chief executive officer of the bank, if he was ignorant of their

truth or falsity, such ignorance was culpable and inexcusable. From these allegations, and the further allegation that the defendant knew that plaintiff's actions in the matter would be governed by his representations as to the bank's financial condition, fraudulent intent that his assurances should be acted upon by the plaintiff may be reasonably inferred."

"Good faith" in cases involving an issue of fraud has been discussed by the South Carolina Supreme Court in several cases, of which *Nettles v. Sottile*, 184 S. C. 1, 191 S. E. 896, is the leading one, in which case it was held:

"The good faith of the defendants in this case must be measured by the legal effects of what they deliberately did. . . . The individual defendant may feel that they acted in good faith, but unfortunately for them, their personal sentiments form no test of law.

" 'Good faith in law, however, is not to be measured always by a man's own standard of right, but by that which it has adopted and prescribed as a standard for the observance of all men in their dealings with each other . . . The good faith of a party under such circumstances must be determined by the legal effect of what he deliberately does.' "

There are several cases brought in Federal Courts sitting in states applying the "good faith" rule in actions to rescind life insurance policies which are of interest here.

In *Guardian Life Ins. Co. v. Clum*, 106 F. (2d) 592, *certiorari* denied, 309 U. S. 666, 60 S. Ct. 592, 84 L. Ed. 1013, the case was governed by the Pennsylvania "good faith" doctrine. The Circuit Court of Appeals held:

"The Pennsylvania cases do not, however, purport to entirely emasculate the processes of recollection. To the

> reasonable working of those processes, then, we must look. In other words, a normal man is not allowed to go too far in basing his good faith on assertions that he has forgotten what those in possession of their ordinary faculties would remember."

In *New York Life Ins. Co. v. McCurdy,* 106 F. (2d) 181, *certiorari* denied, 309 U. S. 656, 84 L. Ed. 1005, a case governed by the statutory "good faith" rule in Kansas, it was pointed out that under the Kansas statute and rule both the state and Federal courts have "consistently held that a false representation knowingly made will avoid the policy, even though the untrue answer was made in good faith. If the false answer knowingly made is material, legal fraud results, even though no conscious purpose to deceive exists."

In *Mutual Life Ins. Co. v. Hurni Packing Co.,* 260 Fed, 641 *certiorari denied,* 251 U. S. 556, 40 S. Ct. 178, 64 L. Ed. 412, which was decided under an Iowa statute requiring proof of "fraud or deceit of the assured," in actions of this kind, with reference to questions and answers concerning consultations with physicians, the court held:

> "The answer having been untrue, and the matter material, and the maker of the statement necessarily knowing that it was untrue when he made it, the intention to deceive the insurer is necessarily implied as the natural consequence of such act." (citing cases)

A case recently decided by the Circuit Court of Appeals for the Fifth Circuit, which arose in Florida and was governed by the good faith rule of that state, is *Metropolitan Life Ins. Co. v. Madden,* 117 F. (2d) 446, in which the issues and the facts are strikingly parallel to those in the instant case. This case is quoted from at length in the opinion of the Circuit Court of Appeals below.

The Circuit Court of Appeals having applied and followed *Johnson v. New York Life Ins. So., supra,* in the determination

of the instant case, and having held that both in law and in fact the character of fraud required under the South Carolina cases has been established by the evidence here, it is respectfully submitted that its decision was correct, and should not be disturbed.

II.

The second question presented by the petition in the instant proceeding is whether the Circuit Court of Appeals, in passing upon the evidence in the case, applied a measure of proof different from that applied in other Circuits.

The contention is that, since the Circuit Court of Appeals stated in its opinion that it had "full power" to review the findings of fact, this must mean that the Court ignored the requirement of Rule 52-a of the Rules of Civil Procedure that "Findings of fact shall not be set aside unless clearly erroneous."

Rule 1 says that

> "These rules govern the procedure in the district courts of the United States in all suits of a civil nature whether cognizable as cases at law or in equity, with the exceptions stated in Rule 81. . ."

Conceding, however, that Rule 52-a applies to the review by the Circuit Court of Appeals of findings of fact in an equity case, it would seem to be a rather strong assumption that because the court used the words "full power" it meant to reverse findings of fact which did not appear to be "clearly erroneous." On the contrary, what the Circuit Court of Appeals said shows beyond question that it regarded the 5th finding of fact of the Special Master as clearly erroneous. It discussed the evidence in detail, and said:

> "We entertain no doubt upon the evidence appearing in the record that the making of the false answers in the application as to matters inquired about, which were false to the knowledge of the applicant when making them, estab-

lished fraud, vitiating the policy within the holding of the *Johnson* case."

And further:

"'the undisputed facts can reasonably give rise to only one infernece, namely, that the policy was procured by fraud.'"

It will be noted that the latter quotation was said by the Court to be made from the *Johnson* case, when it actually was made from the *Parker* case, and the discussion of the *Johnson* case therein.

It is difficult to see how petitioner can contend that the court did not regard a finding of fact as clearly erroneous when the court stated that it entertained no doubt that the contrary conclusion was correct.

The Circuit Court of Appeals must be presumed to have considered the evidence in the light of the applicable rules; it did not state a different rule; the language of the decision shows that its conclusion was consistent with the rule; and the contention that the words "full power" indicated an intention to depart from the rule is exceedingly hypercritical.

It is respectfully submitted that no basis appears for a review of the decision upon the second point presented.

CONCLUSION

It is respectfully submitted that in the decision of the Circuit Court of Appeals, that court properly interpreted the law of South Carolina as established in the decisions of the Supreme Court of the State, and correctly held that, both as a matter of law and under the facts proved in the record, a case warranting the rescission of the policy in question is here presented. The

result reached was required under the binding authority of the *Johnson* case, the leading case in the State, and its review of, and findings on, the facts was well within its power in an equity case, and the result reached is supported by the South Carolina decisions. No basis for the review of the decision has been made out, and it is respectfully submitted that the petition should be denied.

Respectfully submitted,

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